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**ATTACHMENT E: Application Coversheet & Staffing List**

**FY23 CAHC Non-Competitive Application**

|  |  |
| --- | --- |
| Applicant fiduciary name: | CAHC address (*not* fiduciary): |
| CAHC name: |
| Contact Person (name, email, phone): |
| Authorized agency signatory name and title: | |
| Authorized agency signatory email: | |
| Authorized agency signature: | |

|  |
| --- |
| Type of CAHC (*check all that apply*):  Clinical  Alternative Clinical  School Wellness Program  Behavioral Health Services  Network Services Model |
| Physical Location of CAHC (*check all that apply*):   Elementary  Middle School  High School  Alternative High School    Other:  N/A |
| Number of youth in target area/Number of youth in school :\_\_\_\_\_\_\_\_\_\_ |
| Number of unduplicated youth targeted for FY23: ­­\_\_\_\_\_\_\_\_\_\_ |

**Funds Requested**

|  |
| --- |
| Total Amount of Funds Requested: $ |

**Behavioral Health Response Funding Opportunity**

|  |
| --- |
| Yes, our CAHC would like to accept the Behavioral Health Response Funding Opportunity  No, our CAHC would not like to accept the Behavioral Health Response Funding Opportunity |

**Behavioral Health Response Funding Assurances** *(Only check assurances if CAHC would like to accept Behavioral Health Response Funds)*

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| --- |
| Funds are supplemental to support the behavioral response resulting from the impact of COVID. |
| Funds cannot supplant projects, positions, or activities that are already funded or in place by the existing fiduciary, school district, ISD or other collaborating partners. |
| Funds are temporary and only available for FY23. |
| Funding will be used for services in the CAHC target population. |

**Assurances**

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| --- |
| Abortion services, counseling and referrals for abortion services will not be provided as part of the services offered. |
| Services will comply with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the MDHHS and MDE. |
| Family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed (*only check assurance if located on school property*). |
| All CAHC Minimum Program Requirements will be met through the CAHC proposal. |
| CAHC will notify CAHC Agency Consultant in writing within 10 days of main medical or mental health provider absence. |

**Authorized Agency Signatory  
 (***Required)*

|  |
| --- |
| **Authorized agency signature: Date:** |

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FY23 CAHC Staffing List**

List **all** staff members that work in the CAHC (e.g. Coordinator, Medical Director, Medical Provider, Mental Health Provider, Medical Assistant, RN, RD, Dental Hygienist, Outreach Coordinator, Case Manager, Health Educator, etc.).

|  |  |  |  |
| --- | --- | --- | --- |
| **CAHC Site Name:** | | | |
| **Staff Name** | **Title/Position/FTE** | **Email** | **Phone** |
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